STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44E232	A. BUILDING _____ B. WING _____ 04/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLEDSOE COUNTY NURSING HOME	107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1 the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to notify the physician for blood sugar results >400 for two (#8, #9) residents, and failed to clarify the dose of sliding scale insulin to be administered to one (#10) resident of seven residents receiving sliding scale insulin. The findings include: Resident #8 was admitted to the facility on July 24, 2007, with diagnoses including End-Stage Renal disease, Chronic Pain, Hypertension, Insulin Dependent Diabetes Mellitus, Gastroesophageal Reflux Disease, Depression, Peripheral Vascular Disease, and Cerebrovascular Accident. Review of the Physician's Recapitulation Orders dated April 1, 2010, revealed the resident was to receive Lantus Insulin 15 units at bedtime and	F 157	Resident #10: The Physician was contacted and the SSI was changed to a less complicated SSI scale. In-service was conducted by DON & Administrator with the charge nurses on May 5 & 6, 2010, regarding proper use of the Diabetic Record. The physician was notified of SSI errors on April 29, 2010 **2) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?** Upon admission of a new resident, the RNs will review the chart to determine if the resident is a diabetic and will require SSI, if so, the resident will be identified as potential to be affected and measures taken for prevention of error. The RN's - DON - MDS Coord.	4/29/10 5/3/10

Amended information.

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F 157	Continued From page 2 sliding scale insulin, Novolin R, before meals and at bedtime using the scale for blood sugar 200 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; >400 call. Continued review of these orders revealed the original order was dated July 24, 2007, using the same sliding scale. Review of the Diabetic Record for January 2010, February 2010, March 2010, and April 2010, revealed the sliding scale handwritten at the top, was blood sugar 180 - 240 = 2 units; 241 - 280 = 4 units; 281 - 320 = 6 units; 321 - 360 = 8 units; 361 - 400 = 10 units; >400 = call physician. Review of the Diabetic Record revealed the March 11, 2010, at 8:00 p.m., blood sugar was 429 and 10 units of insulin were administered (instead of notifying the physician as ordered. Review of nursing notes for March 11, 2010, revealed no documentation the physician was notified of the blood sugar >400 as ordered. Interview with the Administrator and MDS Coordinator on April 29, 2010, at 9:45 a.m., in the Chapel, confirmed the physician was not notified of the blood sugar results of 429. Resident #9 was admitted to the facility on December 26, 2007, with diagnoses including Diabetes Mellitus, Deep Vein Thrombosis, Pulmonary Embolism, Hypertension, Morbid Obesity, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Osteoarthritis, and Gastroesophageal Reflux Disease. Review of the Physician's Recapitulation Orders dated April 1, 2010, revealed the resident received Lantus 90 units at bedtime and sliding scale insulin, Novolin R, as follows: blood sugar	F 157	3) **WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?** An in-service was conducted on May 5 & 6, 2010 by the DON and Administrator with the charge nurses regarding the use of the Diabetic Record with an explanation on how to correctly fill out each box including checking the comment box and documenting that the physician has been contacted. A copy of the SSI order will be placed with the Diabetic Record, the nurses will compare the order against what is documented on the Diabetic Record and take action to correct if orders are different. The copies were placed by the Dons. The charge nurses will complete audits upon new orders & monthly by the 11-7 charge nurse.	5/6/10

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F 157	Continued From page 3 180 - 240 = 2 units; 241 - 280 = 4 units; 281 - 320 = 6 units; 321 - 360 = 8 units; 361 - 400 = 10 units; >400 = 12 units. Continued review revealed the original order was written on May 5, 2008 for the same sliding scale. Review of the Diabetic Record revealed a hand written sliding scale at the top of the page the same except for blood sugar >400 = call physician. Medical record review of the sliding scale insulin ordered by the physician on April 1, 2010 revealed: April 5, 2010, at 9:00 p.m., blood sugar was 435 and 10 units of insulin were administered (instead of 12 units as ordered). April 20, 2010, at 9:00 p.m., blood sugar was 415 and 10 units of insulin were administered (instead of 12 units as ordered). April 23, 2010, at 9:00 p.m., blood sugar was 451 and 10 unit of insulin were administered (instead of 12 units as ordered). Review of nursing notes for these dates revealed no documentation the physician was notified of the blood sugars >400. Interview with the Administrator and MDS Coordinator on April 29, 2010, at 9:45 a.m., in the Chapel, confirmed Resident #9 had a statement on the Diabetic Record to call the physician if the blood sugar was >400 and there was no documentation the physician was notified of the values, and incorrect doses of insulin were administered for blood sugar >400. Resident #10 was admitted to the facility on September 4, 2007, with diagnoses including Hypertension, Parkinsonism, Chronic Pain, and Diabetes Mellitus.	F 157	The attending physician had been contacted and had changed diabetic to a more consistant SSI. The Diabetic Records will be forwarded to the consultant Pharmacist monthly, by the RN for review of correct orders and documentation. **4) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?** Nurses are performing daily audits to ensure that necessary documentation has been performed, including proper documentation of glucose levels, SSI and routine insulin orders. The RNs will review the Diabetic Records at least twice per	4/29/10 5/11/10 5/10/10

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F 157	Continued From page 4 Review of the Physician's Recapitulation Orders dated April 1, 2010, revealed the resident received Novolin 70/30 insulin 35 units each morning; Lantus insulin 50 units at 4:00 p.m.; as well as sliding scale insulin, Novolin R, of " blood sugar minus 150 divided by 25 = sliding scale insulin dose. Continued review revealed the original order was written on October 27, 2008, with the same sliding scale insulin. Medical record review of the sliding scale insulin ordered by the physician revealed: February 23, 2010, at 8:00 p.m., blood sugar was 389 and 5 units of insulin were administered (instead of 9.56 units per calculation). February 26, 2010, at 9:00 p.m., blood sugar was 321 and 3 units of insulin were administered (instead of 6.84 units per calculation). February 28, 2010, 9:00 p.m., blood sugar was 313 and 10 units of insulin were administered (instead of 6.52 units per calculation). March 2, 2010, at 9:00 p.m., blood sugar was 366 and 8 units of insulin were administered (instead of 8.72 units per calculation). March 3, 2010, at 11:00 a.m., blood sugar was 269 and 4 units were administered (instead of 4.76 units per calculation). March 4, 2010, at 4:00 p.m., blood sugar was 286 and 5 units of insulin were administered (instead of 5.44 units per calculation). March 8, 2010, at 4:00 p.m., blood sugar was 262 and 4 units of insulin were administered (instead of 4.48 units per calculation). March 14, 2010, at 11:00 a.m., blood sugar was 237 and 3 units of insulin were administered (instead of 3.48 units per calculation); at 9:00 p.m., blood sugar was 269 and 4 units of insulin	F 157	week. These findings will be reported to the QA committee monthly until the QA committee deems unnecessary. QA committee: DON Administrator - MDS Coordinator Social Serv. Director Dietary Supervisor Medical Director Consultant pharmacist LPN CNA	5/19/10

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F 322	Continued From page 8 Resident #2 was admitted to the facility on June 30, 2009, with diagnoses including Dementia, Diabetes Mellitus, Congestive Heart Failure, and PEG (percutaneous endoscopic gastrostomy) tube placement. Medical record review of the physician's monthly recapitulation orders signed by the physician on April 16, 2010, stated medications to be given "po (by mouth) or PEG tube... " Review of the facility's Administration of Medication per Gastric Tube policy revealed, " ...Tube placement will be verified by aspiration or insertion of air bolus with auscultation... " Observation of the resident in the resident's room on April 28, 2010, at 9:20 a.m., revealed Licensed Practical Nurse (LPN) #1 providing medication administration to the resident. Continued observation revealed LPN #1 placed a 60 milliliter syringe into the feeding tube and administered medication in 60 milliliters of fluid into the tube without checking placement of the tube prior to medication administration. Interview with LPN #1 outside the resident's room on April 28, 2010, at 10:30 a.m., confirmed the placement of the tube was not checked prior to administering the medication. Interview with the Minimum Data Set Coordinator (MDS) outside the MDS office on April 28, 2010, at 10:35 a.m., confirmed the facility policy for Administration of Medications for residents with PEG tube placement was not followed.	F 322	Administrator, and each nurse given a copy of the policy for PEG tube feedings and administering medications. Also an information note was placed on the MAR of resident # 2 to check for tube placement prior to feedings or medication administration. 2) **HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?** Upon admission of new residents, the RNs will review the chart and orders to determine if the resident has the potential to be affected. If it is determined that the resident will require feedings The RN's: DON & MDS coordinator	
F 333 SS=F	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS	F 333		9A

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F 322	Continued From page 8 Resident #2 was admitted to the facility on June 30, 2009, with diagnoses including Dementia, Diabetes Mellitus, Congestive Heart Failure, and PEG (percutaneous endoscopic gastrostomy) tube placement. Medical record review of the physician's monthly recapitulation orders signed by the physician on April 16, 2010, stated medications to be given "po (by mouth) or PEG tube... " Review of the facility's Administration of Medication per Gastric Tube policy revealed, " ...Tube placement will be verified by aspiration or insertion of air bolus with auscultation... " Observation of the resident in the resident's room on April 28, 2010, at 9:20 a.m., revealed Licensed Practical Nurse (LPN) #1 providing medication administration to the resident. Continued observation revealed LPN #1 placed a 60 milliliter syringe into the feeding tube and administered medication in 60 milliliters of fluid into the tube without checking placement of the tube prior to medication administration. Interview with LPN #1 outside the resident's room on April 28, 2010, at 10:30 a.m., confirmed the placement of the tube was not checked prior to administering the medication. Interview with the Minimum Data Set Coordinator (MDS) outside the MDS office on April 28, 2010, at 10:35 a.m., confirmed the facility policy for Administration of Medications for residents with PEG tube placement was not followed.	F 322	and/or medication per PEG tube, the nurses will be reminded verbally regarding proper checking of placement. Also an information note will be placed on the MAR of any resident requiring PEG tube feedings or medication administration, to check for tube placement prior to feedings or medication administration. The DON or the coordinator MDS will remind the charge nurses 3) **WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?** An in-service was conducted on May 5 & 6, 2010, by the DON and the Administrator with the charge nurses	5/6/10
F 333 SS=F	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS	F 333		9B

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F 322	Continued From page 8 Resident #2 was admitted to the facility on June 30, 2009, with diagnoses including Dementia, Diabetes Mellitus, Congestive Heart Failure, and PEG (percutaneous endoscopic gastrostomy) tube placement. Medical record review of the physician's monthly recapitulation orders signed by the physician on April 16, 2010, stated medications to be given "po (by mouth) or PEG tube... " Review of the facility's Administration of Medication per Gastric Tube policy revealed, " ...Tube placement will be verified by aspiration or insertion of air bolus with auscultation... " Observation of the resident in the resident's room on April 28, 2010, at 9:20 a.m., revealed Licensed Practical Nurse (LPN) #1 providing medication administration to the resident. Continued observation revealed LPN #1 placed a 60 milliliter syringe into the feeding tube and administered medication in 60 milliliters of fluid into the tube without checking placement of the tube prior to medication administration. Interview with LPN #1 outside the resident's room on April 28, 2010, at 10:30 a.m., confirmed the placement of the tube was not checked prior to administering the medication. Interview with the Minimum Data Set Coordinator (MDS) outside the MDS office on April 28, 2010, at 10:35 a.m., confirmed the facility policy for Administration of Medications for residents with PEG tube placement was not followed.	F 322	regarding the policy for checking for tube placement prior to medication or food administration per PEG tube. Each nurse was given a copy of policy. Also, each new admission that requires feedings or medications per PEG tube will have an information note placed on MAR, monthly, reminding nurses to check tube placement prior to medication administration or feedings. The information note was placed on the MAR by the DON - will be done monthly by the pharmacist & checked by 2 charge nurses as MARs are being checked.	9 C
F 333 SS=F	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS	F 333		

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F 322	Continued From page 8 Resident #2 was admitted to the facility on June 30, 2009, with diagnoses including Dementia, Diabetes Mellitus, Congestive Heart Failure, and PEG (percutaneous endoscopic gastrostomy) tube placement. Medical record review of the physician's monthly recapitulation orders signed by the physician on April 16, 2010, stated medications to be given "po (by mouth) or PEG tube... " Review of the facility's Administration of Medication per Gastric Tube policy revealed, " ...Tube placement will be verified by aspiration or insertion of air bolus with auscultation... " Observation of the resident in the resident's room on April 28, 2010, at 9:20 a.m., revealed Licensed Practical Nurse (LPN) #1 providing medication administration to the resident. Continued observation revealed LPN #1 placed a 60 milliliter syringe into the feeding tube and administered medication in 60 milliliters of fluid into the tube without checking placement of the tube prior to medication administration. Interview with LPN #1 outside the resident's room on April 28, 2010, at 10:30 a.m., confirmed the placement of the tube was not checked prior to administering the medication. Interview with the Minimum Data Set Coordinator (MDS) outside the MDS office on April 28, 2010, at 10:35 a.m., confirmed the facility policy for Administration of Medications for residents with PEG tube placement was not followed.	F 322	4) **HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?** The RNs will make random rounds with the charge nurses to ensure proper practice is followed. The findings will be reported and monitored by through the QA committee. The DON or The MDS Coordinator will make rounds with the Charge Nurses Monthly for 6 months to observe Feeding or med. adm.	5/19/10
F 333 SS=F	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS	F 333		9D

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F 333	Continued From page 9	F 333	F 333	

The facility must ensure that residents are free of any significant medication errors.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, facility policy review, and interview, the facility failed to ensure sliding scale insulin was administered according to blood sugar levels, obtained by finger sticks, as ordered by the physician, for six (#4, #5, #8, #9, #10, #11) of seven residents receiving sliding scale insulin. The facility's failure to ensure the sliding scale insulin was administered as ordered by the physician resulted in Substandard Quality of Care.

The findings included:

Resident #4 was admitted to the facility on November 14, 2008, with diagnoses including Diabetes Mellitus, Hypertension, Seizures, Gastroesophageal Reflux disease, and Hyperlipidemia.

Medical record review of the Physician's Recapitulation Orders dated April 1, 2010, revealed the resident was to receive Lantus Insulin 30 units each morning as well as sliding scale insulin with Novolin R before meals and at bedtime using the following sliding scale:
Blood sugar 150 - 200 = 4 units; 201 - 250 = 6 units; 251 - 300 = 8 units; 301 - 350 = 10 units; >350 = 12 units. Continued review revealed the sliding scale insulin was originally ordered on April 7, 2009 using the same sliding scale.
Review of the Diabetic Records for January 2010, February 2010, March 2010, and April 2010, revealed the following scale handwritten at the top

1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICENT PRACTICE?

Resident #4: Chart was reviewed for correct documentation of SSI order on the Diabetic Record. A copy of the order was placed with the Diabetic Record.
Resident #5: Chart was reviewed for correct documentation of SSI order on the Diabetic Record. A copy of the physician's order was placed with the Diabetic Record.
Resident #8: The SSI order was corrected on the Diabetic Record to match the physician's order. A copy of the Physician's order was placed with the Diabetic Record.
Resident# 9: The SSI order was corrected and documented on the Diabetic Record. A copy of the

The MDS coordinator reviewed the chart & made corrections

5/10/10

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F 333	Continued From page 10 of the record: blood sugar " 150 -200 = 4 units; 201 - 250 = 6 units, 251 - 300 = 8 units, 301 - 350 = 10 units, >350 = 12 units. " The Diabetic Record is a form used daily by nurses to administer sliding scale insulin; to document blood sugar values; and the amount of sliding scale insulin administered. Medical record review of the sliding scale insulin ordered by the physician on April 7, 2009, revealed: January 11, 2010, at 6:00 a.m., blood sugar was 166 and no insulin was administered (instead of 4 units as ordered). January 13, 2010, at 8:00 p.m., blood sugar was 174 and no insulin was administered (instead of 4 units as ordered). January 16, 2010, at 6:00 a.m., blood sugar was 205 and no insulin was administered (instead of 6 units as ordered). January 22, 2010, at 8:00 p.m., blood sugar was 198 and no insulin was administered (instead of 4 units as ordered). January 30, 2010, at 6:00 a.m., blood sugar was 152 and no insulin was administered (instead of 4 units as ordered). February 6, 2010, at 4:00 p.m., blood sugar was 415 and 14 units of insulin were administered (instead of 12 units as ordered). February 16, 2010, at 6:00 a.m., blood sugar was 271 and no insulin was administered (instead of 8 units as ordered). February 26, 2010, at 11:00 a.m., blood sugar was 388 and no insulin was administered (instead of 12 units as ordered). March 6, 2010, at 9:00 p.m., blood sugar was 344 and 4 units of insulin were administered (instead of 10 units as ordered).	F 333	The DON placed a copy of the Orders with each diabetic record. Physician's order was placed with the Diabetic Record. Resident #10: The Attending Physician was contacted and he changed the SSI order to a more consistent scale. Resident #11: The SSI order was corrected on the Diabetic Record. A copy of the correct order was placed with the Diabetic Record. These were completed by 5/10/10 2) **HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?** Upon admission of a new resident, the RNs will review the chart to determine if the resident is a diabetic and will require SSI, if so, the resident will be identified as potential to be affected and measures taken for prevention of error. The DON or the MDS Coordinator	

The DON or the MDS will review the chart & the diabetic record to ensure correct documentation after the charge nurse(s) have transcribed orders.

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F 333	Continued From page 11 March 8, 2010, at 4:00 p.m., blood sugar was 262 and 6 units of insulin were administered (instead of 8 units as ordered). March 10, 2010, at 9:00 p.m., blood sugar was 162 and no insulin was administered (instead of 4 units as ordered). March 11, 2010, 9:00 p.m., blood sugar was 263 and 6 units of insulin were administered (instead of 8 units as ordered). March 17, 2010, at 4:00 p.m., blood sugar was 257 and 6 units of insulin were administered (instead of 8 units as ordered). March 20, 2010, at 9:00 p.m., blood sugar was 175 and no insulin was administered (instead of 4 units as ordered). March 22, 2010, at 11:00 a.m., blood sugar was 331 and 8 units of insulin were administered (instead of 10 units as ordered). March 29, 2010, at 4:00 p.m., blood sugar was 415 and 10 units of insulin were administered (instead of 12 units as ordered); at 9:00 p.m., blood sugar was 439 and 10 units of insulin were administered (instead of 12 units as ordered). April 3, 2010, at 9:00 p.m., blood sugar was 336 and 12 units of insulin were administered (instead of 10 units as ordered). April 8, 2010, at 11:00 a.m., blood sugar was 193 and 2 units of insulin were administered (instead of 4 units as ordered). April 17, 2010, at 11:00 a.m., blood glucose was 389 and no insulin was administered (instead of 12 units as ordered). Interview with the Administrator and the Minimum Data Set (MDS) Coordinator, who was acting Director of Nursing, on April 29, 2010, at 9:40 a.m., in the chapel, confirmed Resident #4 was administered incorrect doses of sliding scale insulin and/or doses were omitted when blood	F 333	3) **WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?** An in-service was conducted on May 5 & 6, 2010, by the DON and the Administrator, with the charge nurses regarding the use of the Diabetic Record with an explanation on how to correctly fill out each box including checking the comment box and documenting that the physician has been contacted. A copy of the SSI order will be placed with the Diabetic Record, the nurses will compare the order against what is documented on the Diabetic Record and The charge nurses or the DON or the MDS coordinator will place a copy of the order with the diabetic record upon admission of a resident or upon any med change.	5/10/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44E232	A. BUILDING _____ B. WING _____	04/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLEDSOE COUNTY NURSING HOME	107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 12 sugar values/sliding scale insulin orders indicated sliding scale insulin coverage was indicated. Resident #5 was admitted to the facility on September 11, 2009, and readmitted to the facility on December 3, 2009, with diagnoses including Diabetes Mellitus, Morbid Obesity, Degenerative Spine Disease, Fibromyalgia, Obstructive Sleep Apnea, and Chronic Pain. Review of the Physician's Recapitulation Orders dated January, 2010, revealed an order for " Accucheck AC & HS (before meals and at hours of sleep) with sliding scale insulin, Novolin R, for blood sugar 201 - 250 = 2 units; 252 - 300 = 4 units; 301 - 350 = 8 units; 351 - 400 = 10 units; >400 = 12 units. " Medical record review of the January, 2010 monthly orders for sliding scale insulin revealed: January 6, 2010, at 11:00 a.m., no blood sugar or units of sliding scale insulin administered were documented; January 16, 2010, at 4:00 p.m., blood sugar was 210 and no insulin was administered (instead of 2 units as ordered). January 17, 2010, at 8:00 p.m., blood sugar was 227 and no insulin was administered (instead of 2 units as ordered). January 20, 2010, at 8:00 p.m., no blood sugar or units of sliding scale insulin administered were documented. January 21, 2010, at 11:00 a.m., no blood sugar or units of sliding scale insulin administered were documented. January 30, 2010, at 4:00 p.m., and 8:00 p.m., no blood sugars and units of sliding scale insulin administered were documented.	F 333	take action to correct if orders are different. The attending physician had been contacted and had changed diabetic to a more consistant SSI. The Diabetic Records will be forwarded to the consultant Pharmacist monthly for review of correct orders and documentation. The nurses who re-copies the records on a monthly basic (or as needed) will check the SSI order on the Diabetic Record with the physician's order/MAR. 4) **HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?** Nurses are performing ((charge nurses)	5/10/10

Correct orders will be written & a copy of the correct order will be placed with record of what found to be different

The DON will forward the Records to the Pharmacist & will monthly Review after completion

The IHT nurse will recopy monthly & have complete by the last day of the month

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F 333	Continued From page 13 February 8, 2010, at 4:00 p.m., blood sugar was 219 and no insulin was administered (instead of 2 units as ordered); at 9:00 p.m., blood sugar was 215 and no insulin was administered (instead of 2 units as ordered). March 3, 2010, at 9:00 p.m., blood sugar was 205 and no insulin was administered (instead of 2 units as ordered). March 4, 2010, at 9:00 p.m., blood sugar was 216 and no insulin was administered (instead of 2 units as ordered). March 5, 2010, at 9:00 p.m., blood sugar was 214 and no insulin was administrated (instead of 2 units as ordered). March 20, 2010, at 9:00 p.m., blood sugar was 225 and no insulin was administered (instead of 2 units as ordered). April 5, 2010, at 9:00 p.m., no blood sugar and no units of sliding scale insulin administered were documented. April 25, 2010, no blood sugar and no units of sliding scale insulin administered were documented at 6:00 a.m., 11:00 a.m., and 4:00 p.m.; blood sugar at 9:00 p.m. was 251 and no insulin was administered (instead of 4 units as ordered). Interview with the Administrator and the MDS Coordinator on April 29, 2010, at 9:40 a.m., in the chapel, confirmed Resident #5 was administered incorrect doses of sliding scale insulin and blood sugar values as well as sliding scale insulin administered were not documented consistently. Resident #8 was admitted to the facility on July 24, 2007, with diagnoses including End-Stage Renal disease, Chronic Pain, Hypertension, Insulin Dependent Diabetes Mellitus, Gastroesophageal Reflux Disease, Depression,	F 333	daily audits to ensure that necessary documentation has been performed, including proper documentation of glucose levels, SSI and routine insulin orders. The RNs will review the Diabetic Records at least twice per week. These findings will be reported to the QA committee monthly until the QA committee deems unnecessary. The Diabetic Records will be sent to the Consultant Pharmacist monthly for review of the correct order. The DON Will Send The Records to The Pharmacist & Will Review/monitor after Completion. The QA Committe Consist of: DON - Admin.strator - MDS Coordinator Social Services Director – Dietary Supervisor - Medical Director - pharmacist, aDNA & LPN	5/6/10 - The DON & the MDS Coordinator

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F 425	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on medical record review; review of the Pharmacy Medication Review Report, and interview, the facility failed to ensure the consultant pharmacist conducted comprehensive medication reviews to determine errors and omissions in sliding scale insulin administration for six (#4, #5, #8, #9, #10, #11) of seven residents receiving sliding scale insulin. The findings included: Telephone interview with the Consulting Pharmacist on April 29, 2010, at 10:50 a.m., revealed medication reviews are completed every month on all residents. Continued interview revealed the Consultant Pharmacist does not check the Diabetic Record for correct doses administered since "I assume the staff follow the sliding scale insulin order." Continued interview revealed the Consultant Pharmacist checked the MAR to ensure the medication was given but does not determine the accuracy of the blood sugar value, and stated if an incorrect dose of medication is administered then the facility is notified. Continued interview revealed the Consultant Pharmacist was unaware of the two sliding scale insulin orders with different scale amounts on the MAR and in the Physician's Recapitulation Orders for Resident #4 and stated " That was something I must have overlooked." Continued interview revealed the Consultant Pharmacist is not a member of the Quality Assurance Committee (QAC) and does not attend committee meetings. Continued interview revealed if there are medication issues the Consulting Pharmacist shares those with the	F 425	**2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?** Upon admission of a new resident, the RNs will review the chart to determine if the resident is a diabetic and will require SSI, if so, the resident will be identified as potential to be affected and measures taken for prevention of error **3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?** Monthly the Diabetic Records will be sent to the Consultant Pharmacist for review and to be compared to the Physician's orders for correct documentation of SSI orders. Spoke with Consultant Pharmacist on 5/4/10 and he has agreed to attend QA meetings as necessary.	

06/03/10 08:35AM Bledsoe Nursing Home 4234477465 p.15

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F 425	Continued From page 28 Director of Nursing who relays them to the QAC and if there are issues from the QAC "I have good rapport with the Medical Director and we discuss issues and information." Review of the Medication Review reports submitted from the Consulting Pharmacist revealed there were no irregularities noted in the Medication Administration Records of Residents #4, #5, #8, #9, #10 for December 2009, January 2010, February 2010, and March 2010; and the record of Resident #11 did not have a review due to admission date of March 16, 2010.	F 425	**4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?** See below The QA committee will monitor monthly the audits as well as any recommendations from the Consultant Pharmacist.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked,	F 431	F 431 **1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICENT PRACTICE?** 4/30/10 The medication room was pulled shut as soon as it was realized to be ajar or open. **2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?**	

F425 #4: The QA committee:
DON
Administrator
MDS Coordinator
Social Services Director
Dietary Supervisor
Assistant Director
LPN
CNA

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F 431	Continued From page 30 Interview with the facility Administrator outside the medication room on April 27, 2010, at 7:12 p.m., confirmed the medication room was to remain locked unless attended by authorized staff.	F 431	report any occurrences to the QA committee as well as re-inservicing the nurse(s) responsible. (by the DON or the MDS Coordinator)	
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure clinical records were complete and accurate for six (#4, #5, #8, #9, #10, #11) of seven residents receiving sliding scale insulin. The findings included: Resident #4 was admitted to the facility on November 14, 2008, with diagnoses including Diabetes Mellitus, Hypertension, Seizures, Gastroesophageal Reflux disease, and Hyperlipidemia.	F 514	F 514 **1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICENT PRACTICE?** For residents #4, #8, #9 and #10, the correct SSI was documented on the Diabetic Record after the MDS Coordinator reviewed the Physician's order and compared them to the Diabetic Records. #5 & #11 . The correct SSI was documented on the diabetic record after the MDS Coordinator reviewed & compared orders. **2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?**	4/29/10

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F 514	Continued From page 32 152 and no insulin was administered (instead of 4 units as ordered). February 6, 2010, at 4:00 p.m., blood sugar was 415 and 14 units of insulin were administered (instead of 12 units as ordered). February 16, 2010, at 6:00 a.m., blood sugar was 271 and no insulin was administered (instead of 8 units as ordered). February 26, 2010, at 11:00 a.m., blood sugar was 388 and no insulin was administered (instead of 12 units as ordered). March 6, 2010, at 9:00 p.m., blood sugar was 344 and 4 units of insulin were administered (instead of 10 units as ordered). March 8, 2010, at 4:00 p.m., blood sugar was 262 and 6 units of insulin were administered (instead of 8 units as ordered). March 10, 2010, at 9:00 p.m., blood sugar was 162 and no insulin was administered (instead of 4 units as ordered). March 11, 2010, 9:00 p.m., blood sugar was 263 and 6 units of insulin were administered (instead of 8 units as ordered). March 17, 2010, at 4:00 p.m., blood sugar was 257 and 6 units of insulin were administered (instead of 8 units as ordered). March 20, 2010, at 9:00 p.m., blood sugar was 175 and no insulin was administered (instead of 4 units as ordered). March 22, 2010, at 11:00 a.m., blood sugar was 331 and 8 units of insulin were administered (instead of 10 units as ordered). March 29, 2010, at 4:00 p.m., blood sugar was 415 and 10 units of insulin were administered (instead of 12 units as ordered); at 9:00 p.m., blood sugar was 439 and 10 units of insulin were administered (instead of 12 units as ordered). April 3, 2010, at 9:00 p.m., blood sugar was 336 and 12 units of insulin were administered (instead	F 514	The RNs will monitor the Diabetic Records twice weekly for proper documentation. The findings will be reported to the QA committee monthly until the QA committee deems unnecessary. - The RN's - The DON &/or the MDS Coordinator - QA Committee: - DON - Administrator - Social Services Director - MDS Coordinator - Dietary Supervisor - Medical Director - Consultant Pharm. - LPN - CNA	